

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12382

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles Co</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md 13</u> d. STREET ADDRESS <u>1703 W Fayette St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lonnie</u> First <u>BRANCH</u> Last 4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1956</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 4, 1875</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Field Inspector</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Mutual Life</u> 11. BIRTHPLACE (State or foreign country) <u>M.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Branch</u> 14. MOTHER'S MAIDEN NAME <u>Adeline</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Milton E. Branch</u> Address <u>Balt Md</u>		18. CAUSE OF DEATH [Enter only one cause pending for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHED CHEST SHOCK</u> <u>812x</u> DUE TO <u>COMPOUND FRAC BOTH T.B.A</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u>PEDESTRIAN Hit By Auto</u> DUE TO <u> </u> (d) <u> </u> (e) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>10-12-56</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stegny Suburban Chas Me</u> (City or town) (County) (State)		21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <u>[Signature]</u> EXAMINER'S NAME (Type) <u>Carl</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12/12/56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u> 22d. LOCATION (City, town, or county) <u>Baltimore, Md</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE SIGNED <u>12-10-56</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

DEC 17 1956

RECEIVED

Handwritten signature and text at the bottom of the page.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>White Plains</i>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>White Plains</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Briscoe</i> Middle <i>Buscoe</i> Last		4. DATE OF DEATH <i>12</i> Month <i>10</i> Day <i>19</i> Year <i>56</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 3, 1867</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Charles md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Louis Briscoe</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Marshall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Leon Briscoe</i> Address <i>Washington DC</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conflagration</i> DUE TO (b) <i>Fire destroyed house</i> DUE TO (c) <i>Fire destroyed house</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <i>5-10-56</i> Hour <i>5</i> a. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>White Plains</i> (County) <i>Charles</i> (State) <i>md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Delen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/13/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Josephs</i>		22d. LOCATION (City, town, or county) <i>Pomfret</i> (State) <i>md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Crehart Inc La Plante</i>		24a. REC'D BY REGISTRAR <i>12/12/56</i>	
		24b. REGISTRAR'S SIGNATURE <i>Julius H. Pacey</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12384
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hospital (DOA)</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>5006 Dana Place, N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Dana</u> Middle <u>H.</u> Last <u>Brockway</u>				4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1956</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1902</u>		9. AGE (in years last birthday) <u>54</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months	Days																
	Hours																
	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>title abstracts</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Real estate</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Bert Brockway</u>				14. MOTHER'S MAIDEN NAME <u>Hertude Dana</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nancy Hill 5006 Dana pl NW.</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>12-21-56</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>E. J. EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-21-56</u>													
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Dec. 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Prehort Inc La Plata Md</u>				ADDRESS <u>La Plata Md</u>		24a. REC'D BY REGISTRAR <u>DATE 12/27/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Boney</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

DEC 31 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 11,12,13,14 FilmG208 12-28-56 et

12385

CERTIFICATE OF DEATH

12402

Reg. Dist. No. 106

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Indian Head		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Indian Head			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dispensary, Naval Powder Factory Indian Head, Maryland				STREET ADDRESS (If rural give location) Poplar Lane			
3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) A. (Last) Gregovsky				4. DATE OF DEATH (Month) (Day) (Year) Dec 10 19 56			
5. SEX Male	6. COLOR OR RACE Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov 2, 1903	9. AGE last birthday 53 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Civil Service Navy		11. BIRTHPLACE (State or foreign country) Bohemia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocardial Infarction				20 minutes			
ANTECEDENT CAUSE(S) DUE TO (B) Acute Coronary Occlusion				20 minutes			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Old Coronary Occlusion				6 months			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3:40 12-10, 19 56 , to 3:53 12-10, 19 56 , that I last saw the deceased alive on Dec 10, 19 56 , and that death occurred at 3:53 P.M. from the causes and on the date stated above.							
SIGNATURE E. A. DETTBARN				ADDRESS (Street, city, town, state) Naval Powder Factory, Indian Head, Md.			
DATE SIGNED 12/10/56				DATE SIGNED 10 Dec 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 12/10/56		NAME OF CEMETERY OR CREMATORY Arlington		LOCATION (City, town, or county) (State) Arlington, Va	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Odey Price		25. FUNERAL DIRECTOR'S SIGNATURE Hunt & Ryan, Waldorf Md		ADDRESS	
DATE Dec 10, 1956							

1902

csn1-2010-01

948' 710

5.

02

23

W. J. C. G. 25

1

4. 2. 01

2

5007 3 VC

होलि

0123456789

01211

[illegible]

— 20 —

1990-1991

Academy Country Collection

THE UNIVERSITY OF CHICAGO

BUREAU V. S.

DEC 17 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film G208 12-18-56 et

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JANET Jannett First Lynne Middle Harris Last		4. DATE OF DEATH Month 12 Day 4 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1950
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4	11. IF UNDER 24 HRS. Hours 4 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Marion, N. C.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Morris E. Harris		14. MOTHER'S MAIDEN NAME Lenette Sexton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Charles Hemphill	
17. INFORMANT Charles Hemphill		Address Lexington, Pa., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Asthma 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. J. Edelen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. Edelen, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-5-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Union Mills N.C.		22b. DATE THEREOF 12/5/56	
22c. NAME OF CEMETERY OR CREMATORY Montford Cove		22d. LOCATION (City, town, or county) (State) Union Mills N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Crehant Inc La Plata Md		ADDRESS La Plata Md	
24a. REC'D BY REGISTRAR Julia H Ware		24b. REGISTRAR'S SIGNATURE Julia H Ware	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is partially filled out with handwritten information.

BUREAU V. S.

DEC 11 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third-copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12387

Reg. Dist. No. 100

12406

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>LA PLATA</u>				TOWN <u>WALDORF</u>		RURAL <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>RANDEL</u> (Middle) <u>SCOTT</u> (Last) <u>LASTER</u>				(Month) <u>12</u> (Day) <u>6</u> (Year) <u>56</u>			
5. <u>M</u>	6. COLOR OF RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>12-23-54</u>	9. AGE last birthday <u>2</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>LA PLATA</u>		<u>USA</u>	
13. FATHER'S NAME <u>HASKEL LASTER</u>				14. MOTHER'S MAIDEN NAME <u>IDA MANNIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>HASKEL LASTER WALDORF, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
917.0 IMMEDIATE CAUSE (A) <u>SHOCK</u>						<u>12-5-56</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
						<u>12-5-56</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
				<u>HOME WALDORF CHARLES</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12-5-56</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>FELL IN TUB HOT WATER</u>			
22. I hereby certify that I attended the deceased from <u>12-5-56</u> , to <u>12-6-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-6-56</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. J. Hedden MD</u>		DATE THEREOF <u>12-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Full Gospel Com</u>		LOCATION (City, town, or county) (State) <u>CEDARVILLE MD</u>	
23. BURIAL, CREATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Full Gospel Com</u>		LOCATION (City, town, or county) (State) <u>CEDARVILLE MD</u>	
24. REC'D BY REGISTRAR <u>DEC 10 1956</u>		REGISTRAR'S SIGNATURE <u>Julia Rosey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf, MD</u>	

CERTIFICATE OF DEATH

1. USUAL RESIDENCE (House or Apartment)

2. PLACE OF DEATH

3. OCCUPATION

4. CAUSE OF DEATH

5. MANNER OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. SEX

9. AGE

10. RACE

11. BIRTH DATE

12. BIRTH PLACE

13. MARITAL STATUS

14. EDUCATION

15. RELIGION

16. SOCIAL CLASS

17. OCCUPATION

18. CAUSE OF DEATH

19. MANNER OF DEATH

20. DATE OF DEATH

21. TIME OF DEATH

22. SEX

23. AGE

24. RACE

25. BIRTH DATE

26. BIRTH PLACE

27. MARITAL STATUS

28. EDUCATION

29. RELIGION

30. SOCIAL CLASS

31. OCCUPATION

32. CAUSE OF DEATH

33. MANNER OF DEATH

34. DATE OF DEATH

35. TIME OF DEATH

36. SEX

37. AGE

38. RACE

39. BIRTH DATE

40. BIRTH PLACE

41. MARITAL STATUS

42. EDUCATION

43. RELIGION

44. SOCIAL CLASS

45. OCCUPATION

46. CAUSE OF DEATH

47. MANNER OF DEATH

48. DATE OF DEATH

49. TIME OF DEATH

50. SEX

51. AGE

52. RACE

53. BIRTH DATE

54. BIRTH PLACE

55. MARITAL STATUS

56. EDUCATION

57. RELIGION

58. SOCIAL CLASS

59. OCCUPATION

60. CAUSE OF DEATH

61. MANNER OF DEATH

62. DATE OF DEATH

63. TIME OF DEATH

64. SEX

65. AGE

66. RACE

67. BIRTH DATE

68. BIRTH PLACE

69. MARITAL STATUS

70. EDUCATION

71. RELIGION

72. SOCIAL CLASS

73. OCCUPATION

74. CAUSE OF DEATH

75. MANNER OF DEATH

76. DATE OF DEATH

77. TIME OF DEATH

78. SEX

79. AGE

80. RACE

81. BIRTH DATE

82. BIRTH PLACE

83. MARITAL STATUS

84. EDUCATION

85. RELIGION

86. SOCIAL CLASS

87. OCCUPATION

88. CAUSE OF DEATH

89. MANNER OF DEATH

90. DATE OF DEATH

91. TIME OF DEATH

92. SEX

93. AGE

94. RACE

95. BIRTH DATE

96. BIRTH PLACE

97. MARITAL STATUS

98. EDUCATION

99. RELIGION

100. SOCIAL CLASS

101. OCCUPATION

102. CAUSE OF DEATH

103. MANNER OF DEATH

104. DATE OF DEATH

105. TIME OF DEATH

106. SEX

107. AGE

108. RACE

109. BIRTH DATE

110. BIRTH PLACE

111. MARITAL STATUS

112. EDUCATION

113. RELIGION

114. SOCIAL CLASS

115. OCCUPATION

116. CAUSE OF DEATH

117. MANNER OF DEATH

118. DATE OF DEATH

119. TIME OF DEATH

120. SEX

121. AGE

122. RACE

123. BIRTH DATE

124. BIRTH PLACE

125. MARITAL STATUS

126. EDUCATION

127. RELIGION

128. SOCIAL CLASS

129. OCCUPATION

130. CAUSE OF DEATH

131. MANNER OF DEATH

132. DATE OF DEATH

133. TIME OF DEATH

134. SEX

135. AGE

136. RACE

137. BIRTH DATE

138. BIRTH PLACE

139. MARITAL STATUS

140. EDUCATION

141. RELIGION

142. SOCIAL CLASS

143. OCCUPATION

144. CAUSE OF DEATH

145. MANNER OF DEATH

146. DATE OF DEATH

147. TIME OF DEATH

148. SEX

149. AGE

150. RACE

151. BIRTH DATE

152. BIRTH PLACE

153. MARITAL STATUS

154. EDUCATION

155. RELIGION

156. SOCIAL CLASS

157. OCCUPATION

158. CAUSE OF DEATH

159. MANNER OF DEATH

160. DATE OF DEATH

161. TIME OF DEATH

162. SEX

163. AGE

164. RACE

165. BIRTH DATE

166. BIRTH PLACE

167. MARITAL STATUS

168. EDUCATION

169. RELIGION

170. SOCIAL CLASS

171. OCCUPATION

172. CAUSE OF DEATH

173. MANNER OF DEATH

174. DATE OF DEATH

175. TIME OF DEATH

176. SEX

177. AGE

178. RACE

179. BIRTH DATE

180. BIRTH PLACE

181. MARITAL STATUS

182. EDUCATION

183. RELIGION

184. SOCIAL CLASS

185. OCCUPATION

186. CAUSE OF DEATH

187. MANNER OF DEATH

188. DATE OF DEATH

189. TIME OF DEATH

190. SEX

191. AGE

192. RACE

193. BIRTH DATE

194. BIRTH PLACE

195. MARITAL STATUS

196. EDUCATION

197. RELIGION

198. SOCIAL CLASS

199. OCCUPATION

200. CAUSE OF DEATH

201. MANNER OF DEATH

202. DATE OF DEATH

203. TIME OF DEATH

204. SEX

205. AGE

206. RACE

207. BIRTH DATE

208. BIRTH PLACE

209. MARITAL STATUS

210. EDUCATION

211. RELIGION

212. SOCIAL CLASS

213. OCCUPATION

214. CAUSE OF DEATH

215. MANNER OF DEATH

216. DATE OF DEATH

217. TIME OF DEATH

218. SEX

219. AGE

220. RACE

221. BIRTH DATE

222. BIRTH PLACE

223. MARITAL STATUS

224. EDUCATION

225. RELIGION

226. SOCIAL CLASS

227. OCCUPATION

228. CAUSE OF DEATH

229. MANNER OF DEATH

230. DATE OF DEATH

231. TIME OF DEATH

232. SEX

233. AGE

234. RACE

235. BIRTH DATE

236. BIRTH PLACE

237. MARITAL STATUS

238. EDUCATION

239. RELIGION

240. SOCIAL CLASS

241. OCCUPATION

242. CAUSE OF DEATH

243. MANNER OF DEATH

244. DATE OF DEATH

245. TIME OF DEATH

246. SEX

247. AGE

248. RACE

249. BIRTH DATE

250. BIRTH PLACE

251. MARITAL STATUS

252. EDUCATION

253. RELIGION

254. SOCIAL CLASS

255. OCCUPATION

256. CAUSE OF DEATH

257. MANNER OF DEATH

258. DATE OF DEATH

259. TIME OF DEATH

260. SEX

261. AGE

262. RACE

263. BIRTH DATE

264. BIRTH PLACE

265. MARITAL STATUS

266. EDUCATION

267. RELIGION

268. SOCIAL CLASS

269. OCCUPATION

270. CAUSE OF DEATH

271. MANNER OF DEATH

272. DATE OF DEATH

273. TIME OF DEATH

274. SEX

275. AGE

276. RACE

277. BIRTH DATE

278. BIRTH PLACE

279. MARITAL STATUS

280. EDUCATION

281. RELIGION

282. SOCIAL CLASS

283. OCCUPATION

284. CAUSE OF DEATH

285. MANNER OF DEATH

286. DATE OF DEATH

287. TIME OF DEATH

288. SEX

289. AGE

290. RACE

291. BIRTH DATE

292. BIRTH PLACE

293. MARITAL STATUS

294. EDUCATION

295. RELIGION

296. SOCIAL CLASS

297. OCCUPATION

298.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12388

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Indian Head</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1009 Strauss Ave.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Indian Head</u> STREET ADDRESS (If rural give location) <u>1009 Strauss Ave (9)</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Benjamin</u> (Middle) <u>Ruben</u> (Last) <u>Martin</u>				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>9th</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 2, 1880</u>	9. AGE last birthday <u>76</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Pisgah, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Martin</u>				14. MOTHER'S MAIDEN NAME <u>Baxter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Lezie Scott, Indian Head, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>443x Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive Heart Disease</u>				<u>3 yrs</u>			
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arthritis Left Shoulder</u>				<u>3 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-8</u> , 19 <u>56</u> , to <u>12-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-8</u> , 19 <u>56</u> , and that death occurred at <u>7:54 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank G. Dusan</u> M.D.				ADDRESS (Street, city, town, state) <u>12-9-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Bumpy Oak Cem. Pomonkey, Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>DEC 11 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Gay Price</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12389

CERTIFICATE OF DEATH

12408

Reg. Dist. No. 101

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Charles</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Marbury</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Marbury</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Bertie M. Mitchell</i>				4. DATE OF DEATH (Month) <i>12</i> (Day) <i>29</i> (Year) <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>Aug 10 1897</i>	9. AGE last birthday <i>69</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Bertie Wheeler</i>				14. MOTHER'S MAIDEN NAME <i>Bertie Wheeler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Solomon Mitchell Marbury Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebrovascular Accident</i>				INTERVAL BETWEEN ONSET AND DEATH <i>12-29-56</i> <i>1952</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12-29-56</i> , to <i>12-29-56</i> , that I last saw the deceased alive on <i>12-29-56</i> , 19 <i>56</i> , and that death occurred at <i>5P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>E. E. Edelen</i>				DATE SIGNED <i>12-31-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 1, 1957</i>		NAME OF CEMETERY OR CREMATORY <i>Park Hill Cem</i>		LOCATION (City, town, or county) (State) <i>Marbury Md</i>	
24. REC'D BY REGISTRAR <i>JAN 3 1957</i>		REGISTRAR'S SIGNATURE <i>New Southern</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i>			

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12390
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u>			c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury, Maryland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marbury, Maryland</u>					d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RANDOLPH</u> First <u>MONTGOMERY</u> Last					4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1956</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-13</u>		9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor (Construction)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>Marbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>MARTIN MONTGOMERY</u>			14. MOTHER'S MAIDEN NAME <u>Lottie Mc Jones</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>218-01-1291</u>		17. INFORMANT <u>James Montgomery, Marbury, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRANIOCEREBRAL INJURY</u> <u>823 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto which ran off roadway</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8:30</u> p. m. <u>Dec. 14 1956</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Marbury (street)</u>		20f. (City or town) <u>Marbury</u> (County) <u>Charles</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Paul F. Guerin</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED
EXAMINER'S NAME (Type) <u>PAUL F. GUERIN</u>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					<u>12-16-56</u>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smith's Chapel</u>			22d. LOCATION (City, town, or county) <u>Pasadena</u> (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson and Jenkins</u> ADDRESS <u>1702 12th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>DATE 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Butterland</u>				

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten information.

BUREAU V. S.

DEC 28 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 FilmG208 12-18-56 et

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newburg md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>WAYNE</u> Middle <u>NELSON</u> Last <u>PRICE</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>S</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-56</u>
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dr. Price</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Newburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>SOMMY BRUCE PRICE JR.</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA WATSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u> <u>795.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-7-56</u>		22b. DATE THEREOF <u>St mings</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Newport road.</u>		22d. LOCATION (City, town, or county) (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Inc</u>		ADDRESS <u>Lapata md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 12/8/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Carey</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF REINTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

RECEIVED
DEC 11 1956
BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 FilmG209 1-4-57 et

Reg. Dist. No.

12392

1. PLACE OF DEATH a. COUNTY <i>Charles</i> 12411 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newburgh P.F.D.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leplata</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles Rudolf</i> First Middle Last <i>Robery</i>		4. DATE OF DEATH Month <i>12</i> Day <i>21</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 25, 1918</i>
9. AGE (In years last birthday) <i>38</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Roads</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Luther Robery</i>		14. MOTHER'S MAIDEN NAME <i>Ora Montgomery</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>212-38-3808</i>	
17. INFORMANT <i>Helen Robery</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage into pleural cavity</i> <i>823X</i> DUE TO <i>Crushed Chest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Auto accident</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Driver of auto which hit abutment</i>	
20c. TIME OF INJURY Month, Day, Year <i>12-21-56</i> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway 301</i>		20f. (City or town) (County) (State) <i>Potomac Prince Georges Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Edelen</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>F. J. EDELEN (M.)</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-24-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Washington Natl</i>		22d. LOCATION (City, town, or county) (State) <i>Washington Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wickhart Inc</i>		24a. REC'D BY REGISTRAR <i>12/27/56</i>	
ADDRESS <i>Leplata Md</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Boney</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

DEC 31 1956

RECEIVED

12412

CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>				c. LENGTH OF STAY IN 16 <u>7</u> DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PHYSICIANS MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>—</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK M. SIMMONS</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER 6 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W- U.S.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCTOBER 19, 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROAD INSPECTOR-RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>MARTIN SIMMONS</u>				14. MOTHER'S MAIDEN NAME <u>HANNA QUINLAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW I</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT Address <u>DAVID SIMMONS WALDORF, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS, RIGHT</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIO-SCLEROSIS</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>NOVEMBER 29, 1956</u> , to <u>DECEMBER 6, 1956</u> , that I last saw the deceased alive on <u>DECEMBER 6, 1956</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Griffin</u> M.D.				ADDRESS (Street, city or town, state) <u>Nugheesville, Md.</u> DATE SIGNED <u>12/7/56</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEM</u>		22d. LOCATION (City, town, or county) <u>ARLINGTON, VA.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME</u> ADDRESS <u>WALDORF, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 11 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Julia P. Poy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by a funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 11 1956
BUREAU V. A.

STANDARD FORM NO. 64
OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

1. **TO:** [REDACTED]
2. **FROM:** [REDACTED]
3. **SUBJECT:** [REDACTED]
4. **REFERENCE:** [REDACTED]
5. **DATE:** [REDACTED]
6. **CLASSIFICATION:** [REDACTED]
7. **APPROVAL:** [REDACTED]
8. **REMARKS:** [REDACTED]
9. **ADMINISTRATIVE:** [REDACTED]
10. **OTHER:** [REDACTED]

11. **REMARKS:** [REDACTED]
12. **REMARKS:** [REDACTED]
13. **REMARKS:** [REDACTED]
14. **REMARKS:** [REDACTED]
15. **REMARKS:** [REDACTED]
16. **REMARKS:** [REDACTED]
17. **REMARKS:** [REDACTED]
18. **REMARKS:** [REDACTED]
19. **REMARKS:** [REDACTED]
20. **REMARKS:** [REDACTED]

21. **REMARKS:** [REDACTED]
22. **REMARKS:** [REDACTED]
23. **REMARKS:** [REDACTED]
24. **REMARKS:** [REDACTED]
25. **REMARKS:** [REDACTED]
26. **REMARKS:** [REDACTED]
27. **REMARKS:** [REDACTED]
28. **REMARKS:** [REDACTED]
29. **REMARKS:** [REDACTED]
30. **REMARKS:** [REDACTED]

31. **REMARKS:** [REDACTED]
32. **REMARKS:** [REDACTED]
33. **REMARKS:** [REDACTED]
34. **REMARKS:** [REDACTED]
35. **REMARKS:** [REDACTED]
36. **REMARKS:** [REDACTED]
37. **REMARKS:** [REDACTED]
38. **REMARKS:** [REDACTED]
39. **REMARKS:** [REDACTED]
40. **REMARKS:** [REDACTED]

41. **REMARKS:** [REDACTED]
42. **REMARKS:** [REDACTED]
43. **REMARKS:** [REDACTED]
44. **REMARKS:** [REDACTED]
45. **REMARKS:** [REDACTED]
46. **REMARKS:** [REDACTED]
47. **REMARKS:** [REDACTED]
48. **REMARKS:** [REDACTED]
49. **REMARKS:** [REDACTED]
50. **REMARKS:** [REDACTED]

51. **REMARKS:** [REDACTED]
52. **REMARKS:** [REDACTED]
53. **REMARKS:** [REDACTED]
54. **REMARKS:** [REDACTED]
55. **REMARKS:** [REDACTED]
56. **REMARKS:** [REDACTED]
57. **REMARKS:** [REDACTED]
58. **REMARKS:** [REDACTED]
59. **REMARKS:** [REDACTED]
60. **REMARKS:** [REDACTED]

61. **REMARKS:** [REDACTED]
62. **REMARKS:** [REDACTED]
63. **REMARKS:** [REDACTED]
64. **REMARKS:** [REDACTED]
65. **REMARKS:** [REDACTED]
66. **REMARKS:** [REDACTED]
67. **REMARKS:** [REDACTED]
68. **REMARKS:** [REDACTED]
69. **REMARKS:** [REDACTED]
70. **REMARKS:** [REDACTED]

71. **REMARKS:** [REDACTED]
72. **REMARKS:** [REDACTED]
73. **REMARKS:** [REDACTED]
74. **REMARKS:** [REDACTED]
75. **REMARKS:** [REDACTED]
76. **REMARKS:** [REDACTED]
77. **REMARKS:** [REDACTED]
78. **REMARKS:** [REDACTED]
79. **REMARKS:** [REDACTED]
80. **REMARKS:** [REDACTED]

81. **REMARKS:** [REDACTED]
82. **REMARKS:** [REDACTED]
83. **REMARKS:** [REDACTED]
84. **REMARKS:** [REDACTED]
85. **REMARKS:** [REDACTED]
86. **REMARKS:** [REDACTED]
87. **REMARKS:** [REDACTED]
88. **REMARKS:** [REDACTED]
89. **REMARKS:** [REDACTED]
90. **REMARKS:** [REDACTED]

91. **REMARKS:** [REDACTED]
92. **REMARKS:** [REDACTED]
93. **REMARKS:** [REDACTED]
94. **REMARKS:** [REDACTED]
95. **REMARKS:** [REDACTED]
96. **REMARKS:** [REDACTED]
97. **REMARKS:** [REDACTED]
98. **REMARKS:** [REDACTED]
99. **REMARKS:** [REDACTED]
100. **REMARKS:** [REDACTED]

BUREAU A. 5

DEC 11 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

100

12413

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lan Platan</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy Memorial Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Paul</i> Middle <i>T</i> Last <i>Thompson</i>				4. DATE OF DEATH Month <i>12</i> Day <i>27</i> Year <i>1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec-7-1898</i>	
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months <i>5</i> Days <i>8</i>		IF UNDER 24 HRS. Hours <i>12</i> Min. <i>27</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Talor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>State Road</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>William Thompson</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Thompson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>380-16-8207</i>			
17. INFORMANT <i>Dorothy Thompson</i>				Address <i>Bryantown Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331x</i> DUE TO <i>Cerebrovascular Accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> DUE TO <i>Hypertension</i> (c) <i>Hypertension</i> INTERVAL BETWEEN ONSET AND DEATH <i>12-27-56</i> <i>?</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>No</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. Edelen</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <i>12-27-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>12/31/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>		22d. LOCATION (City, town, or county) (State) <i>Bryantown Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>				ADDRESS <i>12413</i>		24a. REC'D BY REGISTRAR DATE <i>2</i> 1957	
24b. REGISTRAR'S SIGNATURE <i>Julia Carey</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED

JAN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,14,13: G210 1/10/571

CERTIFICATE OF DEATH

Reg. Dist. No.

13106

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSP.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WELCOME	
3. NAME OF DECEASED (Type or print) JOHN ROBERT JAMES TURNBULL		4. DATE OF DEATH Month 12 Day 24 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOV. 1 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	9. AGE (In years last birthday) yrs. 71 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) unk		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANDREW ROBERT TURNBULL		14. MOTHER'S MAIDEN NAME MARY E. (last name unknown) Black	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary E. Garner		Address 22 Ridge Rd. S.E. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular renal 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Gen Art. Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1950 1948	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 to 12-24-56 , that I last saw the deceased alive on 12-24-56 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12-24-56 DATE SIGNED 12-24-56			
ACTUAL SIGNATURE E. S. EDELEN		M.D.	
PHYSICIAN'S NAME (Type) E. S. EDELEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-28-56	22c. NAME OF CEMETERY OR CREMATORY Old Durham Cemetery	22d. LOCATION (City, town, or county) (State) Ironsides, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Julia P. P.	

DEC 28 1956

BUREAU V. S.

DEC 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 102											
1. PLACE OF DEATH a. COUNTY Charles MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE b. COUNTY Chas.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grayton				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X0					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nettie Washington						4. DATE OF DEATH Month Day Year 12 23 1956					
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/1/98		9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Nettie Henson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 12-3-56 6-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE C. J. Edelen						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 4/10/57		
EXAMINER'S NAME (Type) E. J. Edelen						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-26-56		22c. NAME OF CEMETERY OR CREMATORY Oak Grove			22d. LOCATION (City, town, or county) Grayton, Md.			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins 4804 Ga. Ave. N.W.						24a. REC'D BY REGISTRAR DATE 4/25/57		24b. REGISTRAR'S SIGNATURE Lola Thompson			

Film G214, 4/25/57 bh

BUREAU V. 3

APR 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12395

Item 18 Film 208 12-28-56 ans

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 208 12-120-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles 12415 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wayside		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) On highway		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1525 26 St. S.E.	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle A Last WILLIAMS		4. DATE OF DEATH Month December Day 5 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 18 - 1912
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 11 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry S. Deane		14. MOTHER'S MAIDEN NAME Nellie H. Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Veron F. Deane	
17. INFORMANT Veron F. Deane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/6/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Landover Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. H. Lee's Son & Co		ADDRESS 300 4th St. N.E. Wash.	
24a. REC'D BY REGISTRAR DEC 12 1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrich	

RECEIVED

DEC 12 1956

BUREAU V. 3

207-1-110

24

DECEMBER

ATLANTA

MORTUARY

A

Miss

Miss

MAKING STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH